84-1368

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No. 84-

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1984

THE COMMONWEALTH OF MASSACHUSETTS
by its DEPARTMENT OF PUBLIC WELFARE,
Petitioner,

v.

SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

ADMINISTRATOR OF THE HEALTH CARE
FINANCING ADMINISTRATION,

and

THE DEPARTMENTAL GRANT APPEALS BOARD,
Respondents.

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 84-1197

THE COMMONWEALTH OF MASSACHUSETTS,
BY ITS DEPARTMENT OF PUBLIC WELFARE,

Plaintiff, Appellee,

v.

SECRETARY OF HEALTH AND HUMAN
SERVICES, et al.,

Defendants, Appellants.

APPEAL FROM THE UNITED STATES DISTRICT
COURT FOR THE DISTRICT OF MASSACHUSETTS
[Hon. W. Arthur Garrity, Jr.,
U.S. District Judge]

Before

Campbell, Chief Judge,

Bownes, Circuit Judge,

and Perez-Gimenez,* District Judge.

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*Of the District of Puerto Rico, sitting by designation.

November 28, 1984

CAMPBELL, Chief Judge. This appeal involves a dispute between Massachusetts and the Secretary of Health and Human Services ("the Secretary") over Massachusetts's right to be federally reimbursed for certain unrecovered advances to nursing homes. Procedural aspects of the dispute were previously before us in Massachusetts v. Departmental Grant Appeals Board, 698 F.2d 22 (1st Cir. 1983). We held there that 42 U.S.C. § 1316(a)(3) did not authorize direct review by a court of appeals of the challenged decision of the Secretary's Departmental Grant Appeals Board. The instant proceeding was then pending in the district court, Massachusetts having also sought review in the district court from the same agency ruling. See Massachusetts, 698 F.2d at 26. When denying direct court of appeals review, we anticipated

Massachusetts would proceed below, and that the losing party would eventually come to us on appeal. Massachusetts, 698 F.2d at 30. That appeal is now here, the district court having decided in favor of Massachusetts and against the Secretary in an opinion published at 576 F. Supp. 1565 (1984).

I. FACTS

The nature of this dispute is set out in our opinion in Massachusetts, 698 F.2d at 23-24. It arises under the Medicaid statute. 42 U.S.C. § 1396a entitles those states that choose to establish a Medicaid program and that submit to the Secretary a state plan fulfilling the requirements of the Medicaid statute and implementing regulations, to receive federal grants in partial reimbursement of expenses incurred in providing medical

assistance to Medicaid recipients. Federal grants are paid in advance of each quarter based on an estimate provided by the state. 42 U.S.C. § 1396b(d). After actual expenditures are determined, the federal grant for the next quarter is "reduced or increased by the amount of any overpayment or underpayment which the Secretary determines was made." Id. The controverted sums here are ones which the Secretary claims a right to recover as "overpayments," and which Massachusetts strenuously insists are not "overpayments."

To reimburse nursing homes and other health care providers for the medical assistance they render to medicaid recipients, Massachusetts employs a system of interim estimates, sometimes called "retrospective rate-setting." Under this

system (which some but by no means all states employ), Massachusetts begins by setting an interim rate for each provider based on the provider's costs during the previous year. Utilizing this interim rate, Massachusetts then advances to the provider an interim amount at the beginning of each month for the estimated cost of services to be provided that month. Mass. Gen. Laws ch. 6A, § 32. At the close of the rate year, the Massachusetts Rate-Setting Commission performs a complete desk audit of the provider's cost reports, supplemented when necessary by an on-site audit of the provider's books and records, Mass. Admin. Code tit. 114.2, § 2.04(4), to determine the provider's actual costs. A final rate is then set which, if lower than the interim rate, causes Massachusetts to owe to the

provider a smaller amount than it advanced in the past year. Massachusetts undertakes to recover any such differential in its favor by billing the provider or by making offsets against subsequent interim payments. See Mass. Admin. Code tit. 106, § 456.701-.704.

Federal quarterly grants reflect Massachusetts's retrospective rate-setting approach. Thus Massachusetts initially receives from the federal government an amount based on the Commonwealth's interim disbursements to providers. Subsequent grants will reflect any adjustments deemed appropriate in light of final provider rates. In the past, Massachusetts has not reported amounts attributable to any retroactive rate decrease as a decreasing adjustment to the next quarter's federal grant until

it actually recovers the differential from the provider. This practice is in keeping with its view that no "overpayment" has occurred until the state actually recovers the excess amount from the provider.

The instant dispute arose when the Massachusetts Department of Public Welfare ("the Department") failed to recover from certain providers the difference between what it had paid them on the basis of interim rates and the lesser amounts owed to the same providers under smaller final rates. Massachusetts failed to recover because these providers had become bankrupt or were otherwise unable or unwilling to meet their repayment obligations after the final rates took effect. Notwithstanding Massachusetts's inability to recover these

sums,[1] the Secretary insisted that the Commonwealth owed them to her as "overpayments" within the meaning of 42 U.S.C. § 1396b(d)(2). It was and is the Secretary's position that grants to a state under the Medicaid program are limited to the costs incurred for "medical assistance"; and that since these costs are most accurately determined under Massachusetts's retrospective system by the state's own final rates, any overage which the Secretary advanced under less precise interim rates becomes a recoverable overpayment once a final rate is set whether or not the state itself ever recovers it from a provider.

1/ The exact amount at stake in this dispute is unclear. Each party, as well as the district court, cites to a somewhat different figure, but the question of the precise sum is not an issue in this appeal, and we need not try to resolve the disparity.

Massachusetts vigorously protests the Secretary's interpretation. It denies that the sums paid to providers under interim rates are "overpayments," insisting instead that they are a legitimate cost of providing medical assistance until the state itself recoups any differential between the later, final rates. It notes that the Secretary has acquiesced in the Massachusetts system of retrospective rate-setting by her willingness to base initial federal payments on the interim rates. While Massachusetts agrees that it must reimburse the Secretary for all sums actually recovered from providers reflecting the final rates, it contends that it owes no reimbursement for amounts which, in good

faith, it cannot recover.[2]

2/ Each party has an immediate statutory basis for its claim. The Secretary relies on section 1396b(d)(2) which provides as follows:

> (2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. . . .

Massachusetts, on the other hand, relies on section 1396b(d)(3) which reads,

> (3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

In Massachusetts's view, the mere refer-

(footnote continued)

II. PRIOR PROCEEDINGS

This case originated from an audit by HHS's Health Care Financing Administration ("HCFA") of the accounts receivable ledgers of the Massachusetts Department of Public Welfare for the period between April and November 1979. Upon discovering a substantial number of unrecovered excess payments to nursing

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(footnote continued)

ence in section 1396b(d)(2) to "overpayment" does not empower the Secretary to treat the challenged sums as an overpayment. While (d)(2) authorizes the Secretary to reduce a quarterly grant by "any overpayment or underpayment which the Secretary determines was made . . . ," (emphasis supplied), Massachusetts nonetheless argues that the Secretary lacks any right to view the state's unrecovered excess provider payments as such an "overpayment." Only when the state actually recovers the overage from the provider, so that it now conforms to section 1396b(d)(3), does it become a cognizable "overpayment" in the state's view. Until that time, since the state like its partner, the federal government, is out-of-pocket, the state has not -- in this view -- been "overpaid."

homes made under interim rates, HCFA informed Massachusetts that it had determined to disallow Massachusetts's claim for federal financial participation to the extent of that excess, and would reduce HHS's next quarterly grant to Massachusetts by like amount. Massachusetts appealed this disallowance to the Departmental Grant Appeals Board of HHS, which, on February 26, 1982, sustained the disallowance. Departmental Grant Appeals Board Decision 262, No. 80-54-MA-HC (Feb. 26, 1982). On April 22, 1983, Massachusetts brought the action now before us in the United States District Court for the District of Massachusetts pursuant to 5 U.S.C. § 702. The district court disagreed with the Board. 576 F. Supp. at 1568.

The court found that section 1396b(d), the statute governing overpay-

ments, see note 2, supra, was ambiguous, since it did not define the term "overpayments." 576 F. Supp. at 1568. The court felt that either section 1396b(d)(2), which directs the Secretary to reduce the amount of her quarterly grants to a state by the amount of any prior overpayment, or section 1396b(d)(3), which entitles the Secretary to treat as an overpayment her share of medical assistance payments recovered by the state, could on its face govern the amount at issue. Id. The court went on to conclude that the Secretary had presented no evidence to support her characterization of the differentials as section 1396b(d)(2) overpayments. Id. Relying on Harris v. McCrae [sic], 448 U.S. 297 (1981), the Court ruled that the general intent of Congress in enacting the Social Security Act was to create a part-

nership between the states and the federal government in defraying Medicaid costs. Therefore, the Secretary was obliged to bear her share of the loss, since the interim payments giving rise to the supposed overpayments had been made in accordance with a plan that the Secretary had approved. 576 F. Supp. at 1568-69.

III. ARGUMENTS ON APPEAL

The Secretary argues on appeal that the Medicaid statute clearly contemplates that she recover from Massachusetts, as an overpayment, the federal share of the difference between the interim and final rates of reimbursement by Massachusetts to health care providers. She points to 42 U.S.C. § 1396b(a), which provides that "the Secretary shall pay to each State which has a plan approved under this

subchapter . . . (1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan." (Emphasis supplied.) "Medical assistance" is defined in section 1396d(a) as "payments of part or all of the cost of [certain enumerated] care and services," including "skilled nursing facility services." Since Massachusetts ultimately determined that the interim rate at which it reimbursed health care providers was higher than their actual cost of providing health care, so the Secretary argues, the difference is not a cost of "skilled nursing facility services," and so not a cost of medical assistance. Therefore, the Secretary is not required by section 1396b(a) to pay any part of the differ-

ence between Massachusetts's interim and final rates, and indeed is required by section 1396b(d)(2) to subtract her share of that difference from subsequent grants since that difference is an overpayment.

The Secretary's argument turns on the meaning of "cost," a word the statute leaves undefined. The Secretary contends that the rate differentials at issue here are not part of the "cost" of medical assistance, and hence are overpayments. In reaching this result, she argues that two provisions of the Medicaid statute are in pari materia with section 1396d(a) and hence aid in the interpretation of the word "costs." Those provisions are section 1396a(a)(13)(E) as it existed at the time the payments in dispute were made, which requires a state to set rates to nursing homes on a "reasonable cost

related basis," and section 1396a(a)(30), which requires state plans to provide for methods of payments that will assure that payments "are not in excess of reasonable charges consistent with efficiency, economy, and quality of "care." The Secretary argues that these provisions indicate that "cost" as it is used in section 1396d(b) should be construed to mean the cost of care to the providers rather than -- as in the case of unrecovered payments -- the cost of care to the state.

To fortify her construction of the statute, the Secretary insists that as the official authorized by Congress to carry out the Medicaid program, her interpretation of the Medicaid statute is entitled to judicial deference. The Secretary suggests that her argument for

judicial deference is strengthened by the existence of a number of long-standing regulations that govern the recovery of overpayments, see 20 C.F.R. § 201.5(a)(3), .13-.15, and that require her to treat the rate differentials as overpayments.

Massachusetts's contrary argument begins with the same statutory language as the Secretary's. Massachusetts, too, points out that section 1396b(a) directs the Secretary to pay her share of the "amount expended . . . as medical assistance under the State plan." The rate differentials meet both conditions, Massachusetts argues: they were part of the state's cost of medical assistance and, at the time the interim expenditures were made, the amounts were paid out in accordance with a system of prospective rate-setting embodied in Massachusetts's

federally approved state plan. Under Massachusetts's argument, it is immaterial that the interim rate is later found to be in excess of the provider's cost. What is relevant, in its view, is Massachusetts's cost, and here its out-of-pocket expense remains the interim amount it paid out until such time as it may be reimbursed by a provider. Massachusetts cites for its interpretation Massachusetts General Hospital v. Weiner, 569 F.2d 1156, 1158 (1st Cir. 1978), which states that prior to 1972, when standards for the reimbursement of nursing homes were added to the section 1396a requirements for state plans, the word "cost" in the context of section 1396a had meant "costs actually incurred," and that this was the understanding of Congress in drafting section 1396d. Massachusetts

also cites without explanation a number of HHS regulations in effect during the years in question in support of its interpretation of the word "cost." See 42 C.F.R. § 447.252(a), (c), .315(a), .316(a) (1979).

Massachusetts contends that, because the rate differentials were part of the "amount expended . . . as medical assistance under [its] State plan," for the Secretary to deny federal reimbursement for her share of the differentials would amount to the imposition of an additional unauthorized condition on Massachusetts's receipt of federal Medicaid funds beyond those revealed to Massachusetts at the time it agreed to participate in Medicaid. Such an imposition would violate the principle announced in Pennhurst State School v. Halderman, 451 U.S. 1

(1978), that any conditions imposed on the receipt of federal funds by the states be imposed clearly and unambiguously. In support of her contention that the obligation of the Secretary to reimburse is absolute where not expressly conditioned, Massachusetts cites section 1396b(u)(1)(A), which states that the Secretary is barred from reimbursing payments made to ineligible persons where those payments exceed three percent of the total grant to the state "notwithstanding subsection (a)(1)," the subsection imposing the general obligation to reimburse.

As did the district court, Massachusetts also relies upon Harris v. McCrae [sic], 448 U.S. 297, in support of its argument that the federal government is obliged to reimburse the state for its share of the unrecovered rate differen-

tials. In Harris, the Supreme Court described Medicaid in general terms as a partnership between the states and the federal government. According to Massachusetts, this partnership concept requires the Secretary to foot her share of the bill for the differentials.

Finally, Massachusetts contrasts the rule-making authority granted the Secretary under certain sections of the welfare statute -- for example, section 1396a(a)(17)(B), which requires a state plan to make certain payments under "standards prescribed by the Secretary" -- with section 1302, which states that the Secretary "shall make . . . rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration" of her functions. Massachusetts concludes that

though the Secretary is entitled to some deference in her interpretation of the statute, she cannot be allowed to interpret it in a manner inconsistent with its letter, as provided in section 1396b(a), and its spirit as portrayed in Harris.

IV. DISCUSSION

While both sides contend that their interpretation of the Medicaid statute is alone reasonable, the statute, as often happens, is itself less than crystal clear. While the question is close, we are persuaded the Secretary is entitled to prevail.

First, the Secretary's construction that the "cost" of medical assistance is measured by the allowable providers' costs, and does not include reimbursement for excess, unrecovered interim advances, seems to us at least as reasonable as

Massachusetts's contrary interpretation. It is true, as Massachusetts points out, that the cost to Massachusetts of obtaining health care services from providers who went bankrupt before Massachusetts could recover the rate differentials is the cost as determined at the interim rate; that is the amount that Massachusetts actually paid out. However, it can be said that the fair and reasonable cost of those services is the cost as determined in the final rate, and that Congress could scarcely have meant to reimburse a state for excessive cost of services. While the Secretary allows Massachusetts to use a rate-making system which exposes the state to the risk of loss when a provider defaults, the Secretary arguably does not thereby guarantee the state's bad debts. No custom has

been shown, in other Medicare contexts, for federal grants to reimburse a state for losses due to bad debts of this type. Cf. 42 C.F.R. § 447.282 (1979) (state plan generally may not provide for the reimbursement of nursing homes for the homes' bad debts).

To be sure, the Secretary has not pointed to regulations or statutory language lending definitive support to her position. The regulations that she cites, 20 C.F.R. § 201.5(a)(3), .13-.15, all concern when and how the Secretary shall recover overpayments, not whether the rate differentials at issue here are or are not overpayments. And, one of the two statutory subsections she says are in pari materia with section 1396d(a), section 1396a(a)(30), refers to "charges," not "costs." The other, section 1396a(a)(13)(E) as it existed

during the relevant years, which provided that payments to nursing care providers made under the state plan be on a "reasonable cost related" basis, is arguably not inconsistent with Massachusetts's receiving federal reimbursement for payments made to providers at the interim rates, since it can be asserted that those rates were set on a reasonable cost related basis.

On the other hand, the support for Massachusetts's position is likewise inconclusive.

First, the HHS regulations that Massachusetts cites, 42 C.F.R. § 447.252(a), (c), .315(a), .316(a) (1979), simply set ceilings on the amounts that a state plan may disburse to providers. They thus seem to set necessary but not sufficient conditions for Massachusetts's obtaining federal financial participation for its

expenditures. See 42 C.F.R. § 447.252(c) (1979) (federal financial participation is "available" for expenditures within limits).

Second, Massachusetts General Hospital v. Weiner, 569 F.2d 1156 (1st Cir. 1978), the case cited by Massachusetts for the proposition that the word "cost" meant "amount actually expended" at the time section 1396d was enacted, states that proposition without authority and in dicta. The reference is simply too insignificant to be persuasive in this context.

Third, we find both Harris and Pennhurst inapposite. In Harris, the Supreme Court stated that "[t]he cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State," and that "the purpose

of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." Harris, 448 U.S. at 308-09. The issue raised in Harris, however, was whether the states should be required to pay in full for abortions, the cost of which the Secretary was forbidden by statute from contributing to. Harris thus attributes to Congress the intention that no state should be obliged by the Medicaid statute to pay for a service unless the Secretary pays her share, not that the Secretary must pay her share of every out-of-pocket state expense no matter how incurred.

Similarly, Pennhurst differs in crucial respects from the case at bar. In Pennhurst, the statute being construed, the Developmentally Disabled Assistance

and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000 et seq. (1982), contained both a list of specific conditions on the receipt of federal funds and a broad "bill of rights" provision that set out the findings supporting the goals of the Act. The Court held that the latter's statements were merely precatory, imposing no additional obligations on states receiving federal funds under the Act. The present case involves the construction and enforcement of a narrow statutory provision, 42 U.S.C. § 1396b(d). We do not believe that Pennhurst requires that every arguably ambiguous provision conditioning the receipt of federal funds by a state be construed in the state's favor. This conclusion seems supported by the logic of Pennhurst itself. Pennhurst found the imposition of new condi-

tions on the receipt of federal funds repugnant to the notion that by accepting the funds the state had thereby entered into a contract with the federal government and was entitled to have its bargain enforced as written. Pennhurst, 451 U.S. at 17. The present case involves not the imposition of a new condition on the state but the interpretation of the provisions governing the remedies available to the federal government. No principle of contract law requires us to construe such a provision consistently against a federal government obligee. Indeed, in a similar setting, the Supreme Court declined to apply Pennhurst to the construction of an arguably ambiguous provision governing the right of the Secretary of Education to recover federal funds that the state had misspent. Bell

v. New Jersey, 51 U.S.L.W. 4647, 4651-52 n.17 (May 31, 1983).

Whether section 1396b(d)(2) or section 1396b(d)(3) should govern the rate differentials here -- or, in other words, whether the Secretary must wait until a state recovers the differentials before she can recover her share from the state -- is at least unclear, as the district court believed. Whether the differentials are to be covered under section 1396b(d)(2) or (d)(3) boils does [sic] to whether one thinks they are more like those expenses acknowledged to be overpayments, e.g., payments to ineligible recipients, see Medical Services Administration v. United States, 590 F.2d 135 (5th Cir. 1979), or payments to physicians in excess of ceilings established in the state plan, see Georgia v. Cali-

fano, 446 F. Supp. 404 (N.D. Ga. 1977), or are more like those not recoverable by the Secretary until recovered by the state, e.g., Medicaid payments for services already covered by an insurer, see section 1396b(d)(2), second sentence, or payments recovered from a recipient's estate.

Because we find the statutory arguments presented on both sides equally balanced, we turn to considerations of administrative and legislative policy, and here there are at least two reasons to side with the Secretary in this dispute.

First, as the question presented here is one concerning which Congress has given no definitive direction, we believe that it is appropriate to attach some weight to an agency's interpretation of

a statute that it is responsible for administering, that interpretation being both reasonable and statutorily permissible.[3/] This rule is strengthened where Congress has given the administrator explicit rule-making authority, see id., and where the question presented is more concerned with the efficient administration of a program entrusted to the Secretary than with broad questions of policy. As Judge Breyer stated for this court in the recent case of Mayburg v.

3/ See Chevron, U.S.A., Inc. v. National [sic] Resources Defense Council, Inc., 52 U.S.L.W. 4875, 4877 (June 25, 1984). Chevron involved, it is true, a rule-making. But the Chevron Court cited in support of its principle INS v. Jong Ha Wang, 450 U.S. 139 (1981), a case upholding the INS's interpretation of the Immigration and Naturalization Act in a deportation proceeding. See Chevron, 52 U.S.L.W. at 4877 (citing Jong Ha Wang, 450 U.S. at 144). Hence we think the principle is also applicable in an adjudicatory setting, as here.

Secretary of HHS, No. 84-1022, slip. op. (1st Cir. Aug. 2, 1984),

> [t]he less important the question of law, the more interstitial its character, the more closely related to the everyday administration of the statute and to the agency's (rather than the court's) administrative or substantive expertise, the less likely it is that Congress (would have) "wished" or "expected" the courts to remain indifferent to the agency's views.

(Citations omitted.)

Section 1396b(d)(2), moreover, itself commands that federal grants be reduced "to the extent of any overpayment . . . which the Secretary determines was made" (emphasis supplied), thus seemingly entrusting the determination of what constitutes an overpayment to the Secretary. Massachusetts argues that 42 U.S.C. § 1302, the rule-making authority relied on by the Secretary, only empowers her

to make rules "not inconsistent with this chapter," but since we are unable to say that the Secretary's position is inconsistent with the statute, we do not find that argument persuasive. We believe that with respect to matters of this character, where the statute is not explicit, Congress would have intended the Secretary's construction to be given significant weight.

To be sure, the Secretary's obvious pecuniary stake in this case is bound to heighten our scrutiny of her reading of the statute, but the same interest can be found in most cases involving the federal financial participation provisions of the welfare statutes.

Second, the weight of policy seems to us to fall on the side of the Secretary's interpretation. Since Medicaid

is a joint program of the state and federal governments for providing health care, it is appropriate to inquire whether imposing that portion of the rate differential at issue on Massachusetts or the Secretary will better conserve the limited pool of resources available for that purpose. Since only Massachusetts deals directly with the providers, and since the state is empowered to perform on-site audits of these institutions, it is clearly the party best able to minimize the risks resulting from dealing with insolvent providers. The fact that Massachusetts will in any event bear a share of the loss, and so already has some incentive to minimize these risks, diminishes but does not destroy the force of this observation. Placing an additional burden on the state will

increase its incentive to take care, whereas the Secretary remains powerless to reduce the risks no matter what the costs imposed on her.

Additionally, we find some force in the Secretary's argument that while the Secretary accepts Massachusetts's retrospective rate-setting scheme, it does not thereby agree to underwrite provider defaults. The latter are an unintended by-product of the scheme, not an explicit expense. The Secretary may reasonably feel that it is more in keeping with sound administration to gear reimbursement to the fair cost of the providers' services -- a yardstick more generally applicable in all states, many of which have different systems for determining and reimbursing provider costs.

The judgment of the district court

is reversed. We also direct that judgment now be entered in appeal No. 82-1364.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 82-1048-G

COMMONWEALTH OF MASSACHUSETTS by its Department of Public Welfare,

Plaintiff

vs.

MARGARET HECKLER, ET AL,

Defendants

J U D G M E N T

GARRITY, J.

In accordance with the Court's "Memorandum and Order that Judgment be Entered for Plaintiff" entered on January 12, 1984, it is ORDERED:

> that the decision by the Departmental Grant Appeals Board sustaining HHS' disallowance of the $3,703,098 be reversed and set aside, pursuant to 5, USC, §706, that plaintiff's motion for summary judgment is granted

and it is FURTHER ORDERED:

that judgment for the plaintiff declaring that the plaintiff's interim payments to IDAK et al. nursing homes were not, under the attendant circumstances, overpayments within the meaning of 42 USC §1396(d)(2) be, and it is hereby, entered.

By the Court:

STEPHEN A. MOYNAHAN, JR.
Deputy Clerk

Dated: January 13, 1984

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 82-1048-G

COMMONWEALTH OF MASSACHUSETTS by its Department of Public Welfare,

Plaintiff

v.

MARGARET HECKLER, ET AL.,

Defendants

MEMORANDUM AND ORDER THAT JUDGMENT BE ENTERED FOR PLAINTIFF

January 12, 1984

GARRITY, J.

In this action the Commonwealth of Massachusetts (Commonwealth) seeks judicial review, pursuant to 5 U.S.C. § 702, of a final decision of the Departmental Grant Appeals Board (GAB) of the Department of Health and Human Services (HHS). The GAB disallowed approximately $3.7

million in federal Medicaid reimbursement to the Commonwealth to offset a prior overpayment of $3.7 million. The Commonwealth also seeks declaratory and injunctive relief, pursuant to 5 U.S.C. §§ 702, 703 and 28 U.S.C. § 2201, to determine the rights and obligations of the Commonwealth under the Medicaid program, 42 U.S.C. § 1396b et seq., and to prevent the withholding of the federal funds.

The dispute arose following a routine audit of the accounts receivable ledgers of the Commonwealth's Department of Public Welfare (DPW) by the Health Care Financing Administration (HCFA). This agency is a part of HHS, and is responsible for administering the Medicaid program at the federal level. The audit not coincidentally followed the filing in bankruptcy of 27 nursing homes (IDAK

et al) which had been receiving Medicaid payments. On February 21, 1980, HCFA issued its decision that the Commonwealth had overpaid these nursing homes by more than $10 million, so that the Commonwealth owed HHS $5,115,610. This amount represents the amount paid to the Commonwealth by HHS in excess of the final rate, less the amount which had been repaid by the Commonwealth to HHS. HHS was authorized by HCFA to offset this amount against Federal Financial Participation (FFP) owed to the Commonwealth. This offset procedure is known as a disallowance.

The Commonwealth timely appealed this decision to the GAB, which on February 26, 1982 sustained the disallowance and directed the parties to resolve the question of the exact amount owing to HHS.

This was finally accomplished on June 30, 1983, the amount being $3,703,098, but pending this appeal no adjustment has been made to the amounts paid to the Commonwealth.[1/]

On April 22, 1982, the Commonwealth filed actions appealing the GAB's decision in both this court and the United States Court of Appeals for the First Circuit. On August 20, 1982, defendant HHS filed a motion to dismiss in our court. We stayed our decision on this motion pending the decision by the Court of Appeals. On January 12, 1983, the appellate court held that it was without

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1/ Defendant had moved to dismiss for failure to exhaust administrative remedies and for lack of ripeness for judicial review. Both these motions have been mooted by the final administrative determination of the amount owing, and were withdrawn at the hearing.

jurisdiction to hear the case, rejecting plaintiff's argument that this was a "noncompliance" case rather than a disallowance suit. Had it been the former, the Court of Appeals would have had jurisdiction under 42 U.S.C. § 1316(a)(3). The court explained the difference between the two concepts as follows:

> Disallowances typically involve a denial of FFP [Federal Financial Participation] for a narrow item or class of items, and do not, in some general sense, affect the working of the program or federal-state cooperation. Whereas a finding of noncompliance can (although it need not) lead to the cessation of federal participation altogether, a disallowance is merely a retrospective refusal to share in an unauthorized expenditure.

No. 82-1364 at 10. The court found that this was not a compliance matter since it merely involved a dispute over "specific excess payments in certain limited

circumstances, and not . . . the state's overall ratesetting or payment methodology." No. 82-1364 at 21. Were the failure to reimburse HHS its share of excess payments itself to constitute noncompliance, then this would render meaningless the distinction between noncompliance actions and disallowance actions. Since 42 U.S.C. § 1316(a)(3) granted jurisdiction to the Court of Appeals only in noncompliance actions, the court held that it lacked jurisdiction to review the GAB's disallowance decision. It withheld its judgment until further notice, however, so as not to put the Commonwealth in the awkward position of being forced to challenge the ruling by petition for certiorari to the Supreme Court before knowing whether it could obtain review in the district court. The court

authorized the district court to act in related proceedings notwithstanding that judgment has yet to be entered.

On November 30, 1983, we heard argument on defendant's motion to dismiss. Defendant did not press its motion to dismiss for lack of jurisdiction. However, even where jurisdiction is uncontested, it is the court's responsibility to determine whether it has jurisdiction. We hold that it does. County of Alameda v. Weinberger, 9 Cir. 1975, 520 F.2d 344, Woodstock/Kenosha Health Center v. Schweiker, 7 Cir. No. 82-2375, decided July 19, 1983.

The remaining issue is whether plaintiff has failed to state a claim upon which relief may be granted. This turns on whether HHS has correctly interpreted the Medicaid provisions of the Social

Security Act, 42 U.S.C. § 1396 et seq., and in particular, the word "overpayment" in 42 U.S.C. § 1396b(d). To comprehend the arguments of the parties it is worthwhile to review the workings of the Medicaid program.

The Medicaid program is a retrospective reimbursement system under which the state DPW makes provisional payments to health care providers (in this case, nursing homes) at "interim rates" established by the Massachusetts Rate Setting Commission. These rates are based on the amount to which the provider was entitled in previous years. Each quarter, HHS reimburses the Commonwealth at approximately 50% of the interim rate. This reimbursement is called Federal Financial Participation (FFP). Following the close of the rate year, the Commis-

sion establishes a "final rate" based upon the actual costs of the provider during that year. If the final rate exceeds the interim rate, then the health care provider is entitled to receive further payment from the Commonwealth. If, on the other hand, the final rate is lower than the interim one, the Commonwealth is entitled to recover the difference. The issue at hand is whether the Commonwealth should be required to refund HHS its share of this excess whenever the situation occurs, or whether its obligation to refund HHS's share arises only after it obtains repayment by the health care provider.

Surprisingly, there does not appear to be any case law on this subject, and the Medicaid Act itself is ambiguous. The applicable provision, 42 U.S.C.

§ 1396b(d), states in pertinent part as follows:

> (d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a state will be entitled under subsections (a) and (b) of this section for such quarter . . . .
>
> (2) The Secretary shall then pay to the state . . . the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under the section to such state for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the state under subsection (a) of this section shall be treated as an overpayment to the extent that the state . . . has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.2/ (emphasis supplied).

2/ § 1396a(a)(25) provides in essence that where a third party is legally liable to pay for the care and services

(footnote continued)

> (3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the state . . . with respect to medical assistance furnished under the state plan shall be considered an overpayment to be adjusted under this subsection.

A careful reading of the statute exposes the ambiguity. The first sentence of § 1396b(d)(2) permits the Secretary to reduce the amount of FFP to the extent of any overpayment for any prior quarter; § 1396b(d)(3) indicates, however, that certain payments are not to be considered overpayments until the state has recovered the money from the health care provider. Since the term "overpayment" is

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(footnote continued)

available to an individual under the state plan, and this liability was discovered after the medical assistance was made available, the state must seek reimbursement.

nowhere defined in the statute nor in the regulations, it is not clear which subsection applies in the present case.

In support of its position that § 1396b(d)(2) applies, defendant HHS contends that its obligation to reimburse states for medical expenses only covers expenditures based on the final rate; for it is the final rate that corresponds to what the state has determined to be the proper charge for services. Therefore, defendant argues, when a state pays a provider at an interim rate which is higher than the final rate, and HHS reimburses the state for part of that payment, HHS is entitled to disallow its share of the excess over the final rate as an overpayment since that amount was not properly expended by the state for medical assistance under the state plan. HHS also points to various regulations

which establish the authority of the Secretary to disallow improper payments without any condition that the state first recover the money from the provider.

HHS is correct in stating that where there is an overpayment, there need be no recovery by the state before the overpayment can properly be disallowed. However, HHS has not provided any evidence to establish that payment to a state at a higher interim rate than final rate constitutes an overpayment for purposes of § 1396b(d)(2). In the absence of such proof and in light of the policies underlying the Medicaid Act, we do not accept HHS' position.

In our view, to place the full burden of unrecoverable medicaid payments on the states would be inconsistent with the general scheme of the Medicaid pro-

gram, which was intended to function as a partnership between the states and the federal government. As the Supreme Court explained in Harris v. McRae, 1981, 448 U.S. 297, 308-309:

> The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State. Nothing in Title XIX as originally enacted, or in its legislative history, suggests that Congress intended to require a participating state to assume the full costs of providing any health services in its Medicaid plan. Quite the contrary, the purpose of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan. (emphasis added)

Where a state pays a provider at an interim rate in accordance with its state plan, that is a legitimate expenditure for which we believe it is entitled to receive federal financial assistance. If it later turns out through no fault of the state that the interim rate was

higher than the final rate, the prior payment does not suddenly become improper, at least not where HHS approved the plan chosen by the state and the interim payment in question was made in compliance with the plan.

In the event that the state recovers the excess payment from the provider, the pro rata share of HHS in that recovery will be considered an overpayment under § 1396b(d)(3). Until such recovery occurs, however, HHS is not entitled to treat its payments to a state at an interim rate in excess of the final rate as overpayments. Therefore there are no grounds for disallowing the $3,703,098 in federal funds to the Commonwealth. Accordingly, it is ordered that defendant's motion to dismiss or in the alternative for summary judgment be denied, that the decision by the Departmental

Grant Appeals Board sustaining HHS' disallowance of the $3,703,098 be reversed and set aside, pursuant to 5 U.S.C. § 706, that plaintiff's motion for summary judgment be granted and that judgment be entered for the plaintiff declaring that the plaintiff's interim payments to IDAK et al. nursing homes were not, under the attendant circumstances, overpayments within the meaning of 42 U.S.C. § 1396b (d)(2).

W. ARTHUR GARRITY, JR.
United States District Judge

DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Massachusetts Department of Public Welfare
Docket No. 80-54-MA-HC
Decision No. 262

DATE: February 26, 1982

DECISION

The Massachusetts Department of Public Welfare appealed a decision by the Health Care Financing Administration, denying $5,115,610 in federal financial participation (FFP) claimed under the Medicaid program. The disallowance represented the federal share of excess payments to certain nursing homes. The excess payments arose because the State paid each nursing home at an interim rate of reimbursement higher than the final rate established by the State. The State had not recovered the excess payments from the providers, which were bankrupt or no longer participating in the Medi-

caid program.

The State's major argument was that its method of reimbursement, approved by the Agency, necessarily resulted in such excess payments and, therefore, the Agency could adjust for the federal share in the payments only if the State recovered them from the providers. For the reasons stated below, we conclude that the Agency correctly determined that the excess payments were not allowable Medicaid costs and, therefore, FFP in the payments constitutes an overpayment to the State to be adjusted under section 1903(d) of the Social Security Act. Since the State has already adjusted for some of the excess payments, however, we remand to the Agency for the purpose of recalculating the disallowance.

Our decision is based on the written record and briefs.

General Background -- The State's Rate Setting Methodology

Title XIX of the Social Secuirty Act provides for the payment of federal monies to states to aid in financing state medical assistance programs. Any state that wishes to participate in the Medicaid program must develop and submit a plan that meets certain requirements set forth by the Secretary of HHS. Realizing that many states might have difficulty financing a Medicaid program even if subsequently reimbursed by the federal government, Congress also established a funding mechanism by which HHS advances funds to a state, on a quarterly basis, equal to the federal share of the estimated cost of the program. After review of the State's quarterly statement of expenditures, the Secretary may adjust future payments to reflect any overpay-

ment or underpayment which was made to the State for any prior quarter.

Congress gave the states discretion, subject to the Secretary's approval, in formulating an appropriate rate methodology to reimburse providers of Medicaid services. Responsibility for determining the rate at which Medicaid payments for nursing homes will be made in Massachusetts was delegated in the State plan to the Massachusetts Rate Setting Commission (RSC). Paralleling the federal government's method of reimbursing the states under the Medicaid program, Massachusetts developed a system whereby the providers of Medicaid services initially receive compensation at an interim rate.

The RSC sets the interim rate of payment, based on the provider's costs incurred during the previous year, adjusted

for factors such as inflation. The State then releases monthly payments for services rendered during the current year at that rate. This method of estimating ordinarily results in a rate which needs adjusting. Therefore, the actual cost of the services is evaluated at a later date based on a cost report for that year. The RSC audits the cost report for the purpose of establishing a final rate for the reporting period. This may lead to a final rate which is different from the interim rate at which payments were actually made to a provider during the reporting period.[1/]

1/ Although the State did not use precisely this methodology for the entire period in which these excess payments were made, previous systems also gave

(footnote continued)

If the RSC determines that the provider's reasonable, necessary and proper per diem cost of providing services is greater than the interim rate, the provider will have been underpaid. If the provider's cost of services is less than the interim rate, the provider will have been overpaid. A difference between the interim rate and the final rate necessitates a retroactive rate adjustment. The RSC files each retroactive rate adjustment with the Secretary of State.

An office within the DPW, the Retroactive Nursing Home Unit (RNHU), maintains a file for each provider. This file contains copies of all rate adjust-

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(footnote continued)

rise to a need for adjustments, and to possible excess payments. The State has pointed to nothing which would make our legal analysis less applicable to these earlier excess payments.

ments filed with the Secretary of State by the RSC and records showing the amount of underpayment or overpayment which each adjustment produces. If the final rate is lower than the interim rate and a retroactive rate adjustment is required, RNHU calculates the amount attributable to the decrease and records that amount on an Account Receivable Ledger Card. The sum of the amounts shown on a provider's Account Receivable Ledger Card represents the total amount that the RNHU will seek to recover from the provider. If a provider disputes the final rate determination, it may seek administrative review of the final rate by the State office of hearing examiners.

Case Background

As a result of reviews by the Financial Branch of HCFA's Regional Office, HCFA concluded that the State was not

accounting in a timely manner for unrecovered "overpayments" to providers which had received payments at an interim rate higher than a final rate filed by the RSC. The reviewers determined that these "overpayments" should have been accounted for on the State's quarterly statements of expenditures, within two quarters following the quarter in which found, in accordance with 42 CFR 447.296. The results of the reviews were discussed with State agency officials. The amounts disallowed were determined by reviewers who examined the Account Receivable Ledger Cards, maintained by the RNHU. Based on these State records, the Agency disallowed $2,768,367 identified as the federal share of overpayments to bankrupt providers and $2,347,243 identified as the federal share of overpayments to provi-

ders no longer participating in the program.

The Agency cited as a basis for the disallowance the regulation at 42 CFR 447.296, as well as section 1903(d)(2) of the Act. Attached to the disallowance letter was a schedule showing the amounts of the overpayments allegedly made to each provider involved, identifying the provider by number. The amounts were not shown as being related to any specific quarter, although they were identified as overpayments not recovered as of September 30, 1979.

On appeal to the Board, the State raised a number of substantive and procedural arguments. For purposes of this decision, we have discussed the substantive issues under these major headings:

I. Whether the excess payments are overpayments under the statute regardless of recovery.

II. Whether the Agency's regulations are valid and require adjustment for these excess payments.

III. Whether the Agency's approval of the State's reimbursement methodology precludes the Agency from adjusting for these excess payments.

IV. Whether the status of these providers as bankrupt or non-participating providers precludes adjustment.

The issues which are primarily procedural are discussed in the sections headed:

V. Whether the Agency had an adequate basis for its determination that the excess payments constitute an overpayment.

VI. Whether the Agency's disallowance letter was sufficient.

VII. Whether an earlier disallowance is res judicata with respect to part of

the disallowance here.

VIII. Whether the Agency should have instituted a compliance action here rather than a disallowance.

I. Whether the excess payments are overpayments under the statute, regardless of recovery.

A. Substantive basis for adjusting for these excess payments

The State argued that there is no substantive provision in the statute requiring the Secretary to recover an excess payment based on the State's determination of a final reimbursement rate.

We disagree. Section 1903(a) of the Act, the basic provision governing payment of FFP under Medicaid, requires the Secretary to pay each state with an approved plan ". . . an amount equal to the Federal medical assistance percentage of the total amount expended during the quarter as medical assistance under the State plan . . . ." (Emphasis sup-

plied). Section 1905(a) of the Act defines "medical assistance" as "payment of part or all of the cost" of covered services. Other provisions of the statute help define the limits of the allowable cost of such services.2/

2/ Section 1902(a)(30) requires that a State plan provide "methods and procedures relating to . . . the payment for, care and services available under the plan . . . and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care; . . . ." Effective July 1, 1976, a State plan had to provide for payment of nursing home services "on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary." Section 1902(a)(13)(E).

The State alleged that, since its State plan amendment implementing section 1902(a)(13)(E) was not effective until October 1, 1977, excess payments made prior to that date could not be disallowed. However, as indicated in footnote 1 above, the State has not shown any basis for distinguishing payments

(footnote continued)

Here the State provided for a method of payment which used an interim rate, subject to retroactive adjustment. As the State itself indicated, an interim rate is virtually certain to be incorrect since it is based on the adjusted cost of the preceding year. The final rate, on the other hand, is related to the provider's actual cost of providing services under the program. Since it is the final rate that corresponds to what the State has determined to be the proper charge for the services, and therefore, to the amount of the "medical assistance under the State plan," a substantive obligation

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(footnote continued)

determined by the State to be excess payments using other State plan methodologies, set out under 1902(a)(30), from the reasonable cost-related methodology used after October 1, 1977.

exists under section 1903 for the Secretary to allow FFP only in the amount of the final rate.

B. Requirement to adjust once overpayment determined

The State nevertheless argued that the Secretary, under "procedural" provisions of section 1903(d), may recover the federal share of the difference between the interim and final rates only to the extent that the State has already recovered the difference from the providers.

The statutory language does not support this position either, however. Section 1903(d)(1) requires the Secretary to "estimate" the amount that the State will be entitled to under section 1903(a) prior to the beginning of each quarter. Section 1903(d)(2) requires the Secretary to pay the amount so estimated "reduced

or increased to the extent of any overpayment or underpayment which the Secretary determines was made . . . for any prior quarter . . . ." The statute nowhere defines "overpayment." However, the Agency has consistently interpreted the term, together with the provision at section 1116(d) of the Act, to include amounts previously paid to a state, which have been determined to be unallowable. Section 1116(d) of the Act provides for reconsideration by the Secretary of a disallowance, and a final disallowance determination under this section has been interpreted as a basis for an adjustment on the quarterly statement of expenditures under section 1903(d)(2). See, 45 CFR 201.14 (1977).4/

4/ We also note that it is Agency practice in disallowance letters to direct a state to make an FFP adjustment if it does not contest the disallowance.

The State itself recognized that an "overpayment" within the meaning of section 1903(d)(2) has occurred if the State "has failed to comply with the substantive requirements found in other sections of Title XIX." State's December 10, 1981 submission, p. 25. As discussed above, the statute permits FFP only in payments properly made under the State plan. While here the State plan permitted provisional payment to a provider at the interim rate, it authorized final payment only at the final rate.

When the final rate is lower than the interim rate (at which the State claimed FFP), the Secretary properly may determine that an overpayment to the State exists and adjust payments to the State accordingly. Moreover, the overpayment adjustment is not limited under

section 1903(d)(2) to instances where the State has recovered the excess amount from the providers. The section simply authorizes an adjustment based on the Secretary's determination that an overpayment has occurred.

C. Effect of section 1903(d)(3)

The State argued, however, that section 1903(d)(2) should be interpreted more narrowly based on the terms of section 1903(d)(3) and its legislative history. Section 1903(d)(3) requires the Secretary to consider as an "overpayment":

> The pro rata share to which the United States is equitably entitled . . . of the net amount recovered during any quarter by the State . . . with respect to medical assistance furnished under the State plan . . . .

The State argued that this section modifies the conditions for adjusting

overpayments under section 1903 (d)(2) by preventing adjustment until the State has actually recovered the overpayment. The Agency argued persuasively against this interpretation, and we agree for the following reasons:

- Section 1903(d)(3) does not by its terms relate back to all overpayments contemplated by section 1903 (d)(2).

- Since 1903(d)(3) refers to amounts recovered with respect to "medical assistance furnished under the State plan," it reasonably may be viewed as referring to State payments which are allowable "medical assistance" costs. Such instances would include overpayments arising from third party reimbursements as contemplated by section 1902(a)(25); see, also, the second sentence of section 1903(d)(2). Excessive payments to the State arising from an overestimate of provider rates, on the other hand, would not qualify as "medical assistance."

- The extensive legislative history cited by the State primarily supports the Agency's position that section 1903(d)(3) was designed

to authorize the Secretary to adjust in situations such as third party reimbursements where a question might have existed as to the State's liability to repay the federal share or the Agency's authority to recoup the share by an offset to future claims. This interpretation gives full effect to all of the statutory provisions at issue. If Congress had wanted to ensure the State's outcome, it could have done so with a simple amendment to section 1903(d)(2) to limit adjustment of overpayments to situations where a state had already recovered funds.

- Neither the Agency nor the courts have ever interpreted section 1903 (d)(3) so as to prevent adjustment of an overpayment under section 1903(d)(2), irrespective of state recovery from a provider. This applies to overpayments resulting not only from excessive payments, but also from payments made for services or care not covered by the program or for persons ineligible for such care or services. HCFA pointed to sixteen years of consistent application of the statute in its regulations and fiscal procedures and argued that longstanding interpretations of law, which were not disturbed by Congress when it amended the law, are presumed to have the approval of Congress and to be consistent

with Congressional intent.[4]

When the relevant statutory provisions are read as a whole, we believe that the Secretary has a substantive obligation to base Medicaid payments to the State on the State's final rate and need not delay an adjustment necessitated by an overestimate merely because the State has not recovered the excess payments from the provider.[5]

4/ The State did not dispute the Agency's claim that it had this long-standing interpretation and practice. In fact, the record shows that the State had notice of this interpretation as [sic] least as of February 22, 1977. State's December 24, 1980 brief, Ex. D-1.

5/ In our decision in California Department of Health Services, Decision No. 244, December 31, 1981, we discussed the effect of section 1903(d)(3) on the issue of whether a difference between an interim and final rate of reimbursement can be considered an overpayment prior

(footnote continued)

II. Whether the Agency's regulations are valid and require adjustment for these excess payments.

The Agency cited the following provision in support of its position that the State should pay back the federal share of excess payments to providers, regardless of recovery by the State:

> The [State] agency must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found. (See 45 CFR 201.66 for accounting for overpayments.)
>
> (42 CFR 447.296, formerly codified at 45 CFR 250.30(a)(3)(ii)(G))

(footnote continued)

to recovery and reached the same conclusion. However, we have not here relied solely on our analysis in Decision No. 244 but have reexamined the issue in the context of this case and Massachusetts' system of reimbursement.

This provision appears in the context of the regulations establishing requirements for reimbursement of Medicaid providers, including that the State must audit providers' cost reports to ensure that only allowable provider costs are being considered in the rate-setting process.[6/] We agree with HCFA that

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6/ The State argued that 42 CFR 447.296 was not adopted until July 6, 1976 and that, therefore, excess payments made prior to that date could not be disallowed. The State is correct that no regulation existed prior to July 1, 1976 specifying when the State must account for excess payments determined as a result of cost settlement audits. However, the State is not correct concerning the absence of a substantive basis for the disallowance prior to that date. Under the statute, these costs are unallowable and, without the regulation, the Secretary may adjust for the federal share of such excess payments as soon as he determines that it constitutes an overpayment to the State.

this provision supports the interpretation that an excess payment to a provider, found as a result of a cost settlement process, may constitute an overpayment to the State to be adjusted, regardless of whether the State has recovered the amount from the provider. The term "overpayments" in this regulation clearly encompasses a differential between an interim and final rate determined by a state's rate-setting process. The time specified for adjustment in the provision is not contingent on recovery.

The State challenged the regulation, however, on two grounds: That it was invalid as not reasonably related to the purposes of the statute and that, in any event, the Agency had not interpreted the regulation correctly. We discuss these two issues below.

A. Validity of regulation

The State argued that a regulation having the meaning attributed to 42 CFR 447.296 by HCFA would be invalid as plainly inconsistent with the purpose of Title XIX. The State suggested that the effect of the regulation is to impose strict liability on a state for losses sustained under its reimbursement system and that the State, as a partner in the Medicaid program, should not be expected to bear more than a fair share of unavoidable losses. In this respect the State pointed to the limited liability in certain instances of fiscal intermediaries and carriers under the Medicare program. Finally, the State argued that the regulation serves as a disincentive for the State to adopt a retroactive reimbursement system.

We are not persuaded by the State's arguments. With respect to the State's first point, the adjustment for overpayments pursuant to the regulation here is fully consistent with the statute. As we have discussed at length, the statute does not make adjustment contingent on State recovery. The State's position conflicts with statutory intent by permitting the State to retain funds not covered by the program. Moreover, although the Department considered requiring an immediate adjustment for overpayments found in audits, it instead adopted a more liberal rule incorporating a grace period of two quarters. 41 Fed. Reg. 27304 (1976). The State has an automatic adjustment procedure whereby it recovers most of its overpayments stemming from rate changes within this time frame. The absence of exceptions

for bankrupt or non-participating providers in the regulation might be explained in part because this extended time frame was provided for adjusting overpayments generally.

Furthermore, a uniform rule may serve important program purposes by encouraging the State to monitor more closely the financial viability of its providers and to develop systems to recover overpayments before a provider drops out of the program or becomes bankrupt. As the Agency pointed out, the policy may also encourage states to be more precise and conservative in setting interim rates. While the lack of exceptions may indeed serve as a disincentive for the State in selecting this payment option, the option as a whole may have fiscal advantages that counterbalance this factor. Finally, the comparison with the Medicare

program is not convincing here. The State has the primary responsibility under Medicaid for administering its program, and as a consequence might reasonably be expected to assume responsibility for excessive payments to providers, including those where collection has been delayed or even barred.

B. Interpretation of the regulation

As an alternative argument, the State challenged the Agency interpretation of the regulation, arguing that the phrase "account for" should not be interpreted as imposing strict liability on the State, but rather as merely imposing a duty on the State to use reasonable care in promulgating the interim rate and in endeavoring to recover overpayments from providers resulting from rate decreases.

The plain terms of the regulation, however, require the State to account for the overpayments on its quarterly statement of expenditures.[7/] This is reinforced by the preamble to the origi-

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7/ The quarterly statement of expenditures is described in Department regulations as follows:

> This is an accounting statement of the disposition of Federal funds granted for past periods and provides the basis for making the adjustments necessary when the State's estimate for any prior quarter was greater or less than the amount the State actually expended in that quarter. The statement of expenditures also shows the share of the Federal Government in any recoupment, from whatever source, of expenditures claimed in any prior period, and also in expenditures not properly subject to Federal financial participation which are acknowledged by the State agency or have been revealed in the course of an audit.
>
> (45 CFR 201.5(a)(3))

nal provision which specifies that such overpayments must be "accounted for on the SRS OA-41 [now HCFA-64] report." 41 Fed. Reg. 27304, July 1, 1976. Such a report is intended for use in making accounting adjustments, not as a means for the State to report on whether it is fulfilling a duty of using "reasonable care."

Moreover, section 447.296 refers to 45 CFR 201.66 with respect to accounting for overpayments. Section 201.66 deals with repayment of federal funds by a state, permitting a state to make such repayment in installments where certain conditions are met.

The cases cited by the State (State's December 10, 1981 submission, p. 10) do not support the State's interpretation, for the simple reason that they concerned

Department of Agriculture regulations in a totally different context and, therefore, are not relevant to the interpretation of section 447.296.

III. Whether the Agency's approval of the State's reimbursement methodology precludes the Agency from adjusting for these excess payments.

A. Approval of the rate-setting method

The State argued that, since its rate-setting methodology was in accordance with the statute and was approved by the Secretary, the differential between the interim and final rates of reimbursement should not be considered an overpayment. According to the State, while the interim rate is based on the State's best guess as to what the provider's actual costs will be, the interim rate is "virtually certain to be incorrect." (State's December 10, 1981 sub-

mission, p. 11). The State maintained,

> The certainty of error in the interim rate was known to the Secretary when the retrospective rate system was approved. By approving the use of a reimbursement methodology which was virtually certain to result, in some cases, in overpayments to providers, together with the provision that the State would seek to collect those overpayments, the Secretary agreed to share the risk that the overpayments might not be recovered by the State.
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> (State's December 10, 1981 submission, p. 13)

We disagree. While Congress gave the states some leeway in using their own methodologies to determine rates of reimbursement for Medicaid costs, including the possibility of using a retrospective system, the State has pointed to nothing in the statute or its legislative history to indicate that Congress intended to provide FFP in any payments which exceeded the final rate ultimately determined by the State to be

the proper one.[8/]

The purpose of the 1972 amendments on which the State relied in part was to give the states maximum possible flexibility to develop methodologies for cost-finding and reasonable cost-related reimbursement, within the limits set by the Secretary. See, 41 Fed. Reg. 27300, July 1, 1976. Flexibility in the manner of establishing allowable costs cannot be translated, however, into an authorization to pay FFP in costs beyond those

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8/ While the Agency does pay the State for claims for FFP for payments to providers based on an interim rate which is merely an estimate, this payment is only tentative. Payment of the estimate is consistent with the general Title XIX scheme of advance payment to states based on estimates. Section 1903 of the Act. Willingness to pay based on an estimate cannot be considered tantamount to willingness to continue to bear the cost differential between an estimated and final payment, however. As with other advances based on estimates, we think the Agency properly sought an adjustment here.

established by the State as being allowable. The State was permitted to use its own methodology here to establish a reimbursement rate. As the State itself recognized, however, the final rate, once established, represents the amount properly payable under Medicaid on a reasonable cost related basis.

B. Approval of the collection process

The State also argued that its regulations establishing a system for collecting overpayments were expressly approved by the Agency's predecessor, the Social and Rehabilitation Service. According to the State,

> HCFA is therefore estopped from disallowing federal financial participation for amounts which remain uncollected as a result of the [State] Department's adherence to those regulations.
>
> (State's April 28, 1980 submission, p. 4)

The State attempted to read too much into the Agency's approval of the State's collection regulations. By its approval, the Agency merely permitted the State to use a particular method of offsetting past overpayments against future payments due to the providers. As the State acknowledged here, the State system for collection has been interfered with in the case of bankrupt and non-participating providers. (State's December 24, 1980 brief, p. 33). The Agency could reasonably approve use of the State's collection system for other providers and wait for recovery by use of this system for adjustment of FFP, while requiring adjustment without recovery where the State's method of collection has broken down.

Thus, the State has shown nothing in the Agency approval of the State method-

ology for determining the rate, or for collecting overpayments, which could reasonably be relied on as a basis for not adjusting for improper payments to bankrupt or non-participating providers prior to the State's recovery from the providers. We also note that the Agency approval here must be considered in the context of the entire State plan, which defined allowable costs of the program, and which, after November 22, 1976, incorporated the regulatory provision specifying adjustment for overpayments found as a result of an audit no later than the second quarter following the quarter in which the overpayments were found. The State's argument that this plan provision was merely a check on a preprinted State plan amendment form used by the Agency lacks merit. Many State plan provisions are incorporated in this

manner and are no less a part of the State plan than any other provision.

IV. Whether the status of these providers as bankrupt or non-participating providers precludes adjustment.

A. Providers in bankruptcy proceedings

The State argued that it is not liable for that part of the disallowance attributable to overpayments made to providers which subsequently went bankrupt. The State contended that any overpayments made to providers which are in proceedings before a bankruptcy court have been discharged by the Bankruptcy Act and are therefore uncollectable by the State.

In response the Agency argued that while bankruptcy proceedings may discharge a provider's debts to the State, they do not discharge the State's obligations to the Agency. According to the

Agency, "There is no provision in this country's bankruptcy laws which relieve [sic] one debtor from its obligations when it is not bankrupt simply because one of its own debtors has been discharged in bankruptcy." (Agency's October 22, 1981 submission, p. 10). In support of its position, the Agency referred to a bankruptcy proceeding, In re Idak, before the United States Bankruptcy Court, District of Massachusetts. In that proceeding, involving several nursing homes, the State sought to restrain the Secretary of HHS from reducing the State's entitlement to FFP for payments which the State made to the debtors under the Medicaid program. HHS, having reimbursed the State for a percentage of the total Medicaid payments made to the debtor nursing homes, asserted a right

to recoup the full federal portion of any overpayments made by the State to the nursing homes. The State argued that HHS was not entitled to the full share of such overpayments to the debtors. The State also sought a determination from the court that, to the extent any part of its claim against the debtors for Medicaid overpayments was discharged, the State obligation to HHS resulting from such overpayments would likewise be discharged.

In a May 21, 1981 Order Partially Dismissing Proceeding, the court ruled that it lacked jurisdiction to grant the relief requested by the State against HHS. The court declared:

> The dispute between the [State] and the United States is in essence simply between an alleged creditor of the debtors

> and a third-party which has no impact on the debtors or on the Chapter XI [bankruptcy] proceeding.
>
> (p. 3)

While it is true that Congress devised the Medicaid program as a joint federal-state endeavor, Congress gave each state participating in the Medicaid program the authority to administer the program within the state. The matter before us concerns the State's administration of its Medicaid program. It is the State's responsibility to expeditiously recover any overpayments that may have been made. The Agency has no direct role in the recovery of such overpayments. The Agency is not unreasonable, therefore, in requiring the State alone to bear the burden which may result from delays in the collection of overpayments from providers, notwithstanding the fact that the providers might at some

time declare bankruptcy.

We conclude, therefore, that the Agency is entitled to recover from the State the overpayments made even to those providers which may have had their obligation to the State discharged in bankruptcy proceedings.

B. Providers no longer participating in the Medicaid program

Nearly half of the disallowance represents overpayments to providers no longer participating in the Medicaid program. The State claimed that there were several mistakes in the disallowance letter as to what amount was due from specific providers: 21 of the providers had repaid the overpayments to the State which then remitted the federal share to the Agency; the State had sued six of the providers and had obtained at least a partial recovery; and numerous

discrepancies in repayment obligations existed between the amounts shown on the disallowance letter and the State's preliminary analysis. (State's January 8, 1982 submission, pp. 4-5).

The State has not provided the Board with any legal arguments, however, as to why the Agency should be required to wait for repayment once there was a determination that overpayments had occurred. The State's method of collecting the amounts owed by a provider through offset against future payments was a means of recovering overpayments from providers who remained in the Medicaid program. Recovery from providers who dropped out of the Medicaid program may be more difficult as it requires a further action by the State, such as suing for recovery, but that does not excuse the State from refunding the federal share to the Agency. The Agency,

through 42 CFR 447.296, gives the State adequate time to recover these overpayments. It is the State's responsibility to recover these costs and it must bear the consequences for failing to do so.

We find, therefore, that the Agency is entitled to require the State to repay the federal share of overpayments made to providers no longer participating in the Medicaid program. We leave it to the State and Agency, however, to adjust the disallowance if the State has repaid some of the amounts.

V. Whether the Agency had an adequate basis for its determination that the excess payments constitute an overpayment.

The State took the position with respect to the meaning of "overpayment" in 1903(d)(2) that --

> the retrospective rate decrease is simply not "an overpayment . . . which the Secretary determines was made . . . to such State . . ." The overpayment arose out of a determination made by the Rate Setting Commission, not the Secretary, after the Commission reviewed the provider's cost reports and found that the Interim Rate was too high. The overpayment resulting from that determination was made, not to the State, but to the providers.
>
> (State's December 24, 1980 brief, Ex. A-7, p. 6)

We agree with the State that the RSC's determination of a final rate, lower than an interim rate, is not a determination by the Secretary that an overpayment has been made to the State. Moreover, an amount which the State has determined to be an excess payment by the State to a provider is not always an overpayment for federal purposes (e.g., if the State never claimed FFP in the original payment). However, what we are dealing with here is the Agency's deter-

mination that the State, having been paid FFP at an interim rate, which the RSC has now determined to be too high under the State plan, has received an overpayment of Title XIX FFP to the extent of the difference in the two rates. This is a determination that the costs are unallowable for FFP and requires adjustment unless reversed by the Board upon reconsideration.

In examining an Agency disallowance determination, the Board has required that such a determination, to be upheld, must be factually and legally supported by the record. Where the Agency determination is based on State audits or records, the sufficiency of the Agency determination may depend on the reliability of those State audits or records.

The State questioned the basis for the Agency determination in general, as well as pointing to three specific alleged defects:

- The State contended that the disallowance was insufficient in that HCFA had failed to point to any substantive provision in the statute which supported the disallowance, since section 1903 merely deals with the procedure for adjustment once an overpayment determination has been made.

- The State argued that the Agency should not have used the State's Account Receivable Ledger Cards because those records included adjustments which resulted in changes from one interim rate to another or from an interim rate to a final rate which was still subject to adjustment on appeal.

- The State challenged the accuracy of the agency's figures, stating that its analysis showed that the amounts disallowed were wrong.

Based on our examination of the record, however, we have determined that there is an adequate basis for the disallowance, both factually and legally. The

Agency determination here was based on the State's own records, resulting from a process which the State itself has described as follows:

> When a retroactive rate decrease takes effect, the Retroactive Nursing Home Unit calculates the amount attributable to the decrease and enters that amount on separate records, one for each provider, known as the Account Receivable Ledger Cards. At any given time, the sum of the amounts shown on a provider's Account Receivable Ledger Card represents the total amount which the Retroactive Nursing Home Unit will seek to recover from the provider.
>
> (State's December 24, 1980 brief, p. 31)

The Agency auditors used these Account Receivable Ledger Cards in two specified categories (bankrupt providers and providers no longer participating in the program), identifying the particular providers and using the amounts shown on the cards. The amounts clearly related to rates which had been determined, in ac-

cordance with the methodology set out in the State plan, to be in excess of the rates payable under the State plan for the services provided. While the Agency did not initially cite the substantive provisions rendering these costs unallowable, they were implied from the context and clarified in the Agency's response to the appeal.

Although the State questioned the Agency's reliance on the Account Receivable Ledger Cards, the State has not provided any evidence which would convince us that that reliance was misplaced. The State's proposed corrections to the Agency's figures for certain providers are based on recoveries made by the State from the providers subsequent to the time the Agency examined the records. State's January 8, 1982 submission. As the Agency pointed out, however, the fact that

records may be subject to later adjustment does not render them unreliable at any particular point in time. So long as the Agency makes appropriate revisions to the disallowance amounts, as it has indicated a willingness to do here, the State is not prejudiced by use of such records. Moreover, the Account Receivable figures were derived from State audits which the State was required to perform in accordance with generally accepted accounting principles.

The State has also failed to convince us that any excess payment amount reflected in these records derived from a merely tentative rate determination on the part of the State, which might be revised upon subsequent review, or that the records improperly included amounts derived from interim to interim rate decreases. Although the State purported to have evi-

dence that some of the rate decreases here were still under appeal, the State did not submit such evidence as it stated it would. The summary analysis of State documentation (submitted by the State to the Agency at a late stage in the Board's proceedings) contains a column for "Appeals" in which there are no entries. Moreover, we think it unlikely that there are any pending administrative provider appeals concerning the rate decreases in question here given the lapse of time since the RSC rate determinations.

With respect to the question of whether interim to interim rate adjustments were improperly included, we are also unpersuaded by the State's argument. The Agency reviewers described these overpayments as relating to time periods for which the RSC had determined final

rates, and the State has presented nothing to contradict this. It is reasonable to assume that the Account Receivable figures represented net overpayments, taking into account proper adjustments for all interim and final rates, given the State's system of records kept by the RNHU.

Thus, there is no reason for us to believe that the amounts in question did not represent the State's final determinations as to the amounts owed by these providers.[9/]

9/ We also note that the State itself considered any rate filed by the RSC with the Secretary of State to be a sufficient basis for recovery from the provider. See, State's December 24, 1980 brief, p. 31.

VI. Whether the Agency's disallowance letter was sufficient.

The State argued that the Agency's notification of disallowance did not meet the requirements of 45 CFR 201.14(b), in that it failed to set forth either the dates or time periods on which FFP is alleged to have been claimed or the dates on which it was paid. The State claimed that it was prejudiced throughout the proceedings before the Board by the Agency's failure to supply further information on which the disallowance was based. The State cited the Agency's failure to attribute the disallowed amounts to particular quarters as one significant example of the notification's deficiency. The State claimed that various communications from the Agency made it impossible to ascertain the exact date of the review and the periods covered by the disallow-

ance. The State further objected to the Agency's use of a 50% rate for FFP in the disallowance letter as the standard throughout the whole time period covered by the disallowance since the federal medical assistance percentage (FMAP) changed several times during the time period in question. The State said that the 50% rate ceased being effective on October 1, 1977 when the rate was changed to 51.62%. The State contended that the notification of disallowance thus did not adequately set forth a claim for a disallowance and that the Board should therefore dismiss the disallowance.

The State is mistaken in its initial argument that the notification of disallowance had to comply with the requirements of 45 CFR 201.14. The March 6, 1978 transfer to the Board of jurisdiction over reconsideration of disallow-

ances stated that all appeals of disallowances after that date would be governed by the Board procedures set forth at 45 CFR Part 16. The Board rules in effect when this dispute arose state a notification must "set forth the reason for the determination in sufficient detail to enable the grantee to respond . . . ." 45 CFR 16.5(b)(1) (1979). The notification of disallowance issued by the Agency identified the regulations and statutory provisions on which the disallowance was based. The notification also contained a breakdown of the disallowance for each provider, showing the provider's identification number. We find that this was sufficient to meet the requirements of 45 CFR 16.5(b)(1) and provided the State with adequate information to respond to the disallowance. We also note, as the Agency has pointed

out, that all the information on which the disallowance was formulated was gathered from the State's own records, particularly the Account Receivable Ledger Cards.

As to the State's assertion that the Agency improperly used only the 50% FMAP to calculate the disallowance for the entire period in question, we agree with the Agency that the use of this one rate actually benefited the State in the calculation of any possible disallowance. For example, the Agency could have disallowed any FFP claimed after October 1, 1977 at the 51.62% FMAP rate. It is within the Agency's discretion not to disallow at the fullest possible amount if it is administratively convenient to apply one consistent rate. Thus we find that the State was not prejudiced by the Agency's use of the 50% FMAP.

VII. Whether an earlier disallowance is res judicata with respect to part of the disallowance here.

In its latest submission to the Board, the State raised as an additional ground for reversing part of the disallowance before us --

> That for the two year period 1971 and 1972, HCFA has already disallowed the federal share of rate decreases as set forth in Exhibit D of the State's December 24, 1980 submission. That disallowance is res judicata as to the present disallowance; . . .
>
> (State's January 8, 1982 submission, p. 3)10/

10/ The State requested an additional extension of time to brief this and other issues, arguing that the State became aware of the facts underlying these issues only after it had completed its more detailed analysis of the records. The requested extension was denied for a number of reasons, including that the State had had the duty to be aware of sufficient facts to raise the issues prior to that submission. Board's February 12, 1981 Ruling, p. 2.

(footnote continued)

Exhibit D, to which the State refers, is a letter from the Acting Administrator of the Social and Rehabilitation Service (SRS) to the State, upholding a disallowance of FFP in amounts found to represent unrecovered payments to providers in excess of the allowable reimbursement rates. This decision, dated February 22, 1977, was the result of a reconsideration by the Acting Administrator under 45 CFR 201.14, of a disallowance by the Regional Commissioner, SRS. The Acting Administrator recognized that, subsequent to the audit which identified the excess payments, the State had instituted its collection system and had recovered some of the excess payments. Therefore, the

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(footnote continued)

However, as we indicated in our ruling denying the requested extension, we have considered all issues raised by the State, based on the record before us.

Acting Administrator requested the Regional Commissioner to determine the amount to be recovered and to deduct the proper amount from the State's grant award. (p. 3). The decision noted that, as of March 23, 1976, a balance of $202,371 in FFP had not yet been recovered and credited to the federal government.

We agree with the State that this decision would be res judicata with respect to the issue of whether any excess payments covered by the Acting Administrator's decision were allowable. The Acting Administrator determined, however, that they were not allowable. The State as part of its argument on another point appeared to rely on a statement by the Regional Commissioner, made during the reconsideration proceedings for this earlier disallowance, to the effect that,

since the State had instituted collection procedures, the disallowance should be withdrawn. (State's December 24, 1980 brief, Ex. D-11). The record shows, however, that the Acting Administrator did not adopt this position, but upheld the disallowance.

The critical issue, therefore, is whether the State has repaid the federal share of the identified unallowable payments, in accordance with the Acting Administrator's decision. If so, and if the State could show that some of the amounts here duplicated those amounts for which there has already been an adjustment of FFP, the disallowance here should be reduced accordingly. We consider this, therefore, part of the question of the correct quantum of the disallowance. There is no reason to assume that the Agency will not make the proper

adjustment if the State can show that there was, in fact, some duplication of the amounts covered by the Acting Administrator's decision and that the State made the corresponding adjustment of FFP. Since the State has not yet made such a showing, we do not consider this a reason for overturning any part of the disallowance. However, the Agency should consider any documentation submitted by the State on this point, and, if the parties cannot agree on this matter, the State may further appeal it to the Board.

VIII. Whether the Agency should have instituted a compliance action here rather than a disallowance.

The State argued that the dispute raised by the Agency's determination was not a disallowance, but rather a question of program compliance required to be resolved pursuant to section 1904 of

the Act. The State contended that the Board was therefore not the appropriate forum to review this determination as, while the Board has jurisdiction over disallowances arising under section 1116(d), the Board does not have jurisdiction over section 1904 compliance matters.

Both parties submitted extensive briefing on this subject. The Board Chair considered the merits of these arguments when he issued his September 18, 1981 Ruling on Jurisdiction. That Ruling, while declaring that the distinctions between compliance and disallowance issues are often not clear-cut and that the same set of facts could arguably call for either of the procedures, nevertheless held that the facts presented in this case could reasonably be interpreted as a disallowance. The Chair found that

there was no determination that the State's rate methodology to providers involved a substantial noncompliance with the provisions of the Social Security Act requiring a hearing under section 1904. Rather, the Chair found that the Agency had determined that specific payments to certain providers were unallowable costs and that this determination thus met the criteria for a "disallowance."

Recently, in New Jersey Department of Human Services, Decision No. 259, February 25, 1982, the Board examined the compliance/disallowance question in detail, and we refer the parties to that Decision for an extended discussion of the issues. The Board there reviewed the statutory distinctions between these Agency procedures and the court treatment of the issue, including several recent

decisions by the Third Circuit Court of Appeals, in which the State of New Jersey sought appellate review of several Board decisions. The Third Circuit stated that a court of appeals, in determining whether it is an appropriate forum for review of an action by the HHS Secretary, should not be bound by the label the Secretary puts on his action, but rather should "conduct an independent evaluation of the underlying substance of the dispute." State of New Jersey v. Department of Health and Human Services, Nos. 80-2809, 81-1400, 81-1445, 81-2147, and 81-2240 3rd Cir. Dec. 28, 1981, slip op. at 18). In light of the Board's New Jersey decision, we have re-examined what is "the underlying substance of the dispute" here and continue to believe that the Agency could within its discretion take a "disallowance," thereby making

the Board the appropriate forum for review of the Agency's action.

In order for there to be a compliance question, there must be a finding by the Secretary that a state has failed to comply substantially with a provision of its State plan. Even though the State was not meeting one of the requirements of its state plan here, we conclude that the Secretary could reasonably have found that there was no question of substantial noncompliance by the State. The Agency's determination covered only a relatively small segment of the State's whole rate methodology and reimbursement system, namely the recovery of excess payments from those providers who had ceased participating in the Medicaid program or had gone bankrupt. Furthermore, there was no finding that the ultimate program beneficiaries, the Medicaid recipients,

were in any way affected by the questioned State practice.

Further, we do not believe that the State has been prejudiced here by Board review of the Agency's action because the State has been given a full opportunity to present its legal arguments. With respect to the adequacy of the Board's procedures even in a compliance context, the court in New Jersey v. Department of Health and Human Services, No. 80-2438 (3rd Cir. Feb. 5, 1982), stated:

> We find nothing in the Act or its legislative history that precludes our treating the Grant Appeals Board's action on behalf of the Secretary in this dispute as a "final determination" rendered after an "opportunity for hearing" sufficient to satisfy the requirements of [section 1904] and thereby vest jurisdiction in this Court under [section 1116(a)(3)]. (Slip op. at 18 n. 13).

Although the Board did not provide the State with an evidentiary hearing in this case, we believe that the State had sufficient opportunity to present its legal arguments on the issues. While the State did request a hearing to clarify the dates and rates involved here, we believe that any such information concerns only the question of the disallowance amount which we have left to the parties to resolve and not the underlying substantive legal issues. The quantum of unallowable costs would not in any event have been at issue in a compliance proceeding.

Conclusion

For the reasons stated above, we sustain the disallowance. Since the State may have already paid back the federal share of some of the excess payments,

however, the Agency should provide a reasonable opportunity to the State to provide documentation of any such repayment. After reviewing any documentation submitted by the State, the Agency should recalculate the amount of the disallowance, notifying the State in writing if the Agency disputes the State's figures concerning how much has been repaid. The State may then appeal this determination to the Board solely on the issue of how much has been repaid. Nothing in this decision precludes the Agency from adjusting for the federal share of any excess payments not claimed by the State to have been repaid, while the Agency is reviewing the documentation.

Norval D. (John) Settle

Alexander G. Teitz

Donald F. Garrett

Presiding Board Member

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 84-1197

THE COMMONWEALTH OF MASSACHUSETTS
BY ITS DEPARTMENT OF PUBLIC WELFARE,
Plaintiff, Appellee,

v.

SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.,
Defendants, Appellants.

JUDGMENT

Entered: November 28, 1984

This cause came on to be heard on appeal from the United States District Court for the District of Massachusetts, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the District Court is reversed. No costs.

By the Court:

FRANCIS P. SCIGLIANO, Clerk

Text of Statutes Involved

Section 1903 of the Social Security Act, 42 U.S.C. § 1396b, provides in pertinent part as follows:

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966 --

(1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan . . .

* * *

(d) Estimates of State entitlement; installments; adjustments; overpayment; obligated appropriations; disputed claims.

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) of this section for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such

other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with

section 1396a(a)(25) of this title.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

Section 1905 of the Social Security Act, 42 U.S.C. § 1396d, provides in pertinent part as follows:

§ 1396d. Definitions

For purposes of this subchapter --

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and ser-

vices (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals . . . who are --

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter.

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under sub-chapter XVI of this chapter, or

(viii) pregnant women.

but whose income and resources are

insufficient to meet all of such cost --

* * *

(4)(A) skilled nursing facility services . . . for individuals of 21 years of age or older . . .,

* * *

(15) intermediate care facility services . . . for individuals who are determined in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care . . . .